DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER: 9 7 — 0 7

2. STATE: MICHIGAN

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)

TO: REGIONAL ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
~~January~~ April 1, 1997 RAH per 5/14/01 submission

5. TYPE OF PLAN MATERIAL *(Check One)*:

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION:
42 CFR

7. FEDERAL BUDGET IMPACT:
a. FFY 1997 $ N/A
b. FFY 1998 $ N/A

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
Attachment 4.19-A, pp. 3 and 29

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
Attachment 4.19-A, pp. 3 and 29

10. SUBJECT OF AMENDMENT:
Extension of Submission Time to File Cost Report
New Definition of Rural Hospital

11. GOVERNOR'S REVIEW *(Check One)*:

☒ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☐ OTHER, AS SPECIFIED:

12. SIGNATURE OF STATE AGENCY OFFICIAL:
[signature]

13. TYPED NAME:
For James K. Haveman, Jr.

14. TITLE:
Director

15. DATE SUBMITTED:
4-11-97

16. RETURN TO:
Mich Dept of Community Health
Medical Services Administration
PO Box 30479
Lansing MI 48909

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED:
04/15/97

18. DATE APPROVED:
6/6/01

PLAN APPROVED - ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:

20. SIGNATURE OF REGIONAL OFFICIAL:
[signature]

21. TYPED NAME:
Cheryl A. Harris

22. TITLE:
Associate Regional Administrator
Division of Medicaid and Children's Health

23. REMARKS:

RECEIVED
APR 15 1997
HCFA-V-DMMCP

FORM HCFA-179 (07-92)

Instructions on Back

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
State: MICHIGAN

METHODS OF PAYMENT OF REASONABLE COSTS -
INPATIENT HOSPITAL SERVICES

II. Cost Reporting and Audit

A. Cost Reporting

Hospitals must complete and submit a cost report on the form and in the format designated by the Michigan Medical Services Administration (MSA) in accordance with the instructions related to the Medicaid Program. The hospital's cost report must:

- be HCFA-2552 forms (modifications or changes to meet program needs may be required),
- follow the Medicare Principles of Reimbursement Manual (HIM 15 and 15-1) and all applicable parts of 42 CFR Chapter IV,
- be prepared using the accrual method of accounting (unless an alternative method is approved by the MSA),
- be a separate cost report as well as distinct-part accounting for Medicare certified distinct-part units, and
- include all information necessary for proper determination of costs payable under the program including financial records and any needed statistical data.

For cost reporting purposes, the MSA requires each eligible hospital provider to submit periodic reports which generally cover consecutive 12 month periods of operation. Inpatient and/or outpatient cost reports must be filed within five (5) months of the end of the hospital's cost reporting year. State owned hospitals must file cost reports within 180 days after the end of the State's cost reporting year.

Extensions of the filing period may be granted when exceptional circumstances establish good cause. If the hospital requests an extension in writing and documents the exceptional circumstances prior to the date due, extensions may be granted up to a maximum of 30 days. Failure to submit all necessary items and schedules will only delay processing and will result in a reduction of payment or termination as a provider.

Hospitals that fail to submit cost reports as defined previously will receive a delinquency letter from the MSA. If the cost report is not submitted within 30 days of the notice of delinquency, a second notice of delinquency will be issued. If the cost report is not submitted within 30 days of a second notice of delinquency, the provider's payments will be stopped. Restitution of withheld payments will be made by the State agency after receipt, of an acceptable cost report.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
State: MICHIGAN

METHODS OF PAYMENT OF REASONABLE COSTS -
INPATIENT HOSPITAL SERVICES

2. Rural Hospitals

If a hospital is located in a rural area (defined as located outside a city of 40,000 or more people by a distance of 10 miles or more and based on U.S. Census Bureau population data) capital reimbursement will be limited if occupancy in the hospital is less than 60% during the hospital's fiscal year. For hospitals with occupancy less than 60%, the Medicaid reimbursement for capital will be:

$$\frac{Occupancy}{0.6} \times Medicaid\ Share\ of\ Capital$$

If occupancy is at least 60%, the Medicaid reimbursement for capital will be 100% of the Medicaid share of Capital.